Gerontological Advanced Practice Nurses Association – GAPNA - IN SUPPORT OF RAISED BILL No. 67

AN ACT CONCERNING THE AUTHORITY AND RESPONSIBILITIES OF ADVANCED PRACTICE REGISTERED NURSES

Senator Gerratana, Representative Ritter and members of the Committee,

Thank you for raising this bill and for advocating for improved health care for the citizens of our state.

I am Elizabeth Esstman, an Advanced Practice Registered Nurse practicing in the state of Connecticut. I am a graduate of the Yale University School of Nursing and I am certified as a Gerontological Nurse Practitioner. I have been practicing at Hebrew Healthcare in West Hartford, Connecticut for over 14 years. I am representing the New England Chapter of the Gerontological Advanced Practice Nurses Association here today.

As you all are aware, APRNs are permitted to practice solely as codified in the Connecticut General Statutes Section 20-87a, commonly referred to as "The Nurse Practice Act". However, the omission of the term "Advanced Practice Registered Nurse" throughout multiple sections of the Connecticut General Statutes has prevented APRNs from fully utilizing our license resulting in obstruction of care to many, including some of our most vulnerable citizens – older adults.

According to Public Health Code 19a-580d, a Do Not Resuscitate or DNR order is defined as "an order written by a Connecticut licensed physician to withhold cardiopulmonary resuscitation…", commonly referred to as CPR. As this is currently written, APRNs are restricted from documenting a patient's desired plan of care at the end of life, which is in direct conflict with the intent of The Nurse Practice Act.

Such states as Maine, New Hampshire, and Vermont that allow full autonomous practice of APRNs similar to CT, allow APRNs to write DNR orders. Furthermore, multiple states which are more restrictive of APRN practice than CT, such as Massachusetts, Virginia, and North Carolina permit APRNs to write DNR orders for their patients. This reality highlights the disconnect between Connecticut allowing full autonomous practice of APRNs but restricting them from writing DNR orders.

In Connecticut, APRNs are typically the only providers present in skilled nursing facilities on a daily basis. Currently, if a patient in a nursing facility wishes to change their code status to DNR

they have to wait until a physician is available to discuss this change with them. If a patient becomes acutely ill and expresses a wish not to be resuscitated to the APRN managing their care and at their bedside, that change may not be able to be made immediately, and may not be made for several days until a physician is accessible. If that patient goes into cardiac arrest after deciding they do not want to be resuscitated but before a physician is available to change their order, they could be resuscitated against their wishes.

Examples of how the currently worded statute interferes with quality of care are numerous. For example, one APRN in Connecticut was the only provider in a skilled nursing facility when an 89 year-old patient developed a cardiac arrhythmia at 3 a.m. and became acutely ill. The patient was begging staff not to transfer her to the hospital but she did not have a DNR status documented. A physician was not available to come into the facility to change the patient's advanced directives at 3 a.m. and the patient had to be transferred to the hospital against her wishes. Another APRN working in a nursing facility is haunted by a memory of a patient admitted with a new diagnosis of metastatic cancer that was too advanced for any chemotherapy or radiation. The patient desired palliative or comfort care only but had not yet been seen by a physician so did not have a DNR order documented. The patient developed acute respiratory distress due to fluid in her lungs from the cancer. Although the patient and her son, who was an out of state physician, were clear they did not want aggressive care, this patient had to be sent back to the hospital against her and her family's wishes because there was not a physician on site to change the order and no time to wait for one to arrive. Not only was this woman who had verbalized a desire to die peacefully, transferred to the hospital in an ambulance, but she also was tortured with aggressive medical intervention during transfer, including insertion of IV lines and ventilation.

These are just several real life stories that illustrate how the inclusion of APRNs in Section 19a-580d, as proposed in Section 23 of this bill, would improve end of life care for our older adults in nursing facilities. And the same is true for other settings. Patients have a right to make end of life decisions, a right that is being denied to many ill patients because statutes do not yet recognize the APRN license and the APRN patient.

Nurses have always played a vital role in end of life care, especially in Connecticut, as nurse Florence Wald established the first hospice in the United States right here in Connecticut in 1974. APRNs have the education and training to have end of life discussions with patients, we simply need the support of the Legislature to allow us to practice to our full potential under the Nurse Practice Act.

Another point to consider is that resuscitation is not only a traumatic experience, but it is also very costly. The personnel, equipment, and medications required for cardiopulmonary resuscitation, as well as the necessary post event hospitalization are impressive and expensive. While these health care costs are unavoidable in a cardiac arrest patient wishing for aggressive

intervention, they are avoidable in a cardiac arrest patient who wants to allow natural death but has not yet had that discussion with a physician so that their wishes can be documented in accordance with the current Connecticut statute. The financial and ethical impact of delivering unwanted and unnecessary care is a substantial burden on the health care system, and is an inefficient use of our very scarce and valuable resources.